A Lexington Medical Center Physician Practice

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LexPlasticSurgery.com

Patient History

Name:____ Date of Birth:_______________

Home Phone:_______________ Cell Phone:_______________ Email:_______________________________

Are there any restrictions for contacting you? ☐ Yes ☐ No If yes, contact restrictions:_______________________________

____

Do you give us permission to leave a message on answering machine? ☐ Yes ☐ No Occupation:_______________________

TODAY'S VISIT

What brings you to see us?

How did you hear about Dr. Lefkowitz/Lexington Plastic Surgery? ☐ Friend/Family Member ☐ Magazine Article (which one) _______________
Internet: ☐ Random Search/Google ☐ RealSelf ☐ Lexmed.com ☐ Angie's List ☐ American Society of Plastic Surgeon's website

How did you hear about Dr. Lefkowitz/Lexington Plastic Surgery?	Referring Physician (if any):

MEDICAL/SURGICAL HISTORY

PERSONAL MEDICAL HISTORY: Please list any medical conditions for which you are/have been treated (include any hospitalizations)

	TYPE OF CONDITION/HOSPITALIZATION	DATES TREATED
1		
2		
3		
4		
5		

PAST SURGICAL HISTORY:

	TYPE OF OPERATION	SURGEON/LOCATION	DATE
1			
2			
3			
4			
5			

NON-SURGICAL COSMETIC PROCEDURES:
Please list any non-surgical cosmetic procedures you have had and where. (E.g. Botox – forehead; Chemical peel – face; Fillers – face)

REVIEW OF SYSTEMS:
Please answer the following yes/no questions to the best of your ability. Do you have any of the following conditions, illnesses or symptoms?

HEMATOLOGIC/ONCOLOGIC	Yes	No
Breast Disease		
Bleeding Tendency		
Easy Bruising		
Anemia		
Sickle Cell Disease		
Blood Clots in Legs		
Blood Clots in Lungs		
Radiation Therapy		
CARDIOVASCULAR	**Yes**	**No**
High Blood Pressure		
Heart Attack		
Angina/Chest Pain		
Heart Bypass Surgery		
Pacemaker		
Heart Failure		
Irregular Heartbeat		
Do you exercise? Comments:		
NEUROLOGICAL	**Yes**	**No**
Stroke		
Seizures		
Dizziness		
Headache		
Depression		
Anxiety		
Bi-Polar		
ENDOCRINE	**Yes**	**No**
Diabetes		
Thyroid Disease		
Taken Steroids		

RESPIRATORY	Yes	No
Asthma		
Bronchitis		
Emphysema		
Recent Chest Infection		
Shortness of Breath (at rest/on exertion)		
Dry Cough		
Cough with Sputum		
Sleep Apnea		
Use a C-Pap machine?		
URINARY/REPRODUCTIVE	**Yes**	**No**
Kidney Disease		
Urinary Disease		
Dialysis		
MUSCULOSKELETAL	**Yes**	**No**
Sciatica		
Herniated Disk (neck, back)		
Arthritis		
Rheumatoid Arthritis		
Neck, Back, Arm, Leg Problems		
Back/Neck Surgery		
INFECTIOUS/GASTROINTESTINAL	**Yes**	**No**
Jaundice		
Hepatitis		
Stomach Ulcers		
Hiatal Hernia		
Heartburn		
HIV/Aids		
SKIN	**Yes**	**No**
Basal Cell Skin Cancer		
Squamous Cell Skin Cancer		
Melanoma		
Staph Infection		
Problems with Scarring (E.g. keloids, widened, etc.)		

If yes to any of the above, please explain below:

ALLERGIES/REACTIONS:

PLEASE ANSWER THE FOLLOWING YES/NO QUESTIONS TO THE BEST OF YOUR ABILITY.	**Yes**	**No**
Do you have any allergic or unusual reactions to medications, anesthesia, or other substances (e.g. latex)? If yes, please list:		
Do you have any allergies to iodine/I.V. contrast agents?		
Do you experience cold sores or fever blisters?		

MEDICATIONS:

Please list all medications you take presently and within the last six months.

	MEDICATION NAME	DOSAGE IN MILLIGRAMS OR GRAMS	FREQUENCY (E.G. ONCE A DAY)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

HERBAL/SUPPLEMENTS/VITAMINS:

List any herbal supplements you are taking (e.g. Ginko, Ginger, Garlic, St. John's Wort, Saw Palmetto, Flax Seed, etc.): ______________________________

____

List any vitamins (e.g. Vitamin C, E, Fish Oils) you are taking: ______________________________

GYNECOLOGICAL/WOMEN'S HEALTH:

Number of Pregnancies:	C-Sections:	Miscarriages/Spontaneous Abortions:	Year of Last Pregnancy:

Do you currently or have you ever breast fed? ☐ Yes ☐ No

Is there any possibility you could be pregnant at this time? ☐ Yes ☐ No

Are you on birth control (e.g. oral contraceptives or estrogen, have an IUD or intravaginal device, use the patch or take injections) ☐ Yes ☐ No

SOCIAL HISTORY:

Are you a smoker or use tobacco? ☐ Yes ☐ No If yes, how many pack per day and for how long have you smoked:

Quit how long ago:	Do you use the nicotine patch or gum? ☐ Yes ☐ No	How much alcohol do you drink:

Recent weight change? ☐ Yes ☐ No If yes, ☐ Increase (up) ☐ decrease (down) How much?

IS THERE ANY OTHER SPECIFIC PROCEDURE OR TREATMENT YOU ARE INTERESTED IN LEARNING ABOUT?

Signature______________________________ Date:______________